

SUBSTANCE USE DISORDER PROGRAM RELAPSE PREVENTION PLAN

NAME: _____

Number of days of continuous recovery: _____

Identified triggers to use:

Intervention for the trigger:

Names and phone numbers of people I can call 24/7:

- | | | | |
|----------|-------|--------|-------|
| 1. Name: | _____ | Phone: | _____ |
| 2. Name: | _____ | Phone: | _____ |
| 3. Name: | _____ | Phone: | _____ |
| 4. Name: | _____ | Phone: | _____ |
| 5. Name: | _____ | Phone: | _____ |
| 6. Name: | _____ | Phone: | _____ |

Number of meetings I am committed to attend each week: _____

Location of those meetings:

Healthy lifestyle changes I am committed to making:

Situations in which I am most likely to use:

Steps I will take to avoid these situations:

What I will lose if I return to substance use:

Return to recovery plan if I do use:

Unresolved issues:

Referrals I have been given to address these issues:

Date: _____

Patient Signature: _____